

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16137

FILED JUN 4 1943 318

State File No. 4613

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis.  
(b) City or town St. Louis.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2217 N. 10th St. /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 50 Years. (Specify whether years, months or days)

3. (a) PRINT FULL NAME John M. Grace.

3. (b) If veteran, name war. No. 3. (c) Social Security No. None.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Late Emma R. Grace. 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased April 16 1860.  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
83 1 1 hr. min.

9. Birthplace Hopkinsville, Kentucky.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Watchman.

11. Industry or business.

12. Name Eden Grace.  
13. Birthplace Kentucky.  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown.  
15. Birthplace Unknown.  
(City, town, or county) (State or foreign country)

16. (a) Informant Beulah Carter.

(b) Address 2217 N. 10th St.

17. (a) Burial (b) Date thereof 5-19-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hopkinsville, Ky.

18. (a) Signature of funeral director Hy. Leidner Und. Co.

(b) Address 2223 St. Louis Ave.

19. (a) MAY 18 1943 (b) J. F. Budeck (c) Registrar's signature

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County St. Louis.  
(c) City or town St. Louis.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2217 N. 10th St.  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17  
year 1943 hour 2 P.M. minute M.

21. I hereby certify that I attended the deceased from May 17 1943, to May 17 1943, that I last saw her alive on May 17 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy 1 day  
arterio sclerosis 5.

Due to not known!

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: Of operations none  
Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) none  
(b) Date of occurrence.  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature Dr. N. F. Miller M. D. Date signed 5-19-43  
Address 8410 N. Broadway St. Kansas Mo

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

---

---

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Werner L. Ponder*

Licensed Embalmer No.

*3367*

P. O. Address

*2223 St. Louis Ave*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**